

Adult General History Form

Name:	Date of Birth:
Active Problems:	
Past Major Medical Problems:	
Surgeries:	
Medications, herbs, and supplements used:	
Allergies: (to medicine, environment, food and other)	

Family History	Age at death	Check if they had					Other medical conditions
		Heart disease	Stroke	Diabetes	Osteo-porosis	Cancer	
Father							
Mother							
Brother							
Sister							

Social History						
Marital Status:		Single <input type="checkbox"/>	Married <input type="checkbox"/>	Separated <input type="checkbox"/>	Divorced <input type="checkbox"/>	Widowed <input type="checkbox"/>
Occupation: _____		<input type="checkbox"/> Retired	<input type="checkbox"/> Disabled	<input type="checkbox"/> Unemployed		
Religion: _____			Place of worship: _____			
Drug Use:		I currently use... <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> Other _____				
<input type="checkbox"/> Never use <input type="checkbox"/> Recovering addict						
Alcohol:	<input type="checkbox"/> Never Drank <input type="checkbox"/> Rarely Drink <input type="checkbox"/> Daily drinker <input type="checkbox"/> Weekend drinker <input type="checkbox"/> Recovering Alcoholic					
Smoking:	<input type="checkbox"/> Never Smoked <input type="checkbox"/> Used to Smoke <input type="checkbox"/> Smoke Sometimes <input type="checkbox"/> Smoke Every Day					

**** Please bring your immunization records to office visit, thank you ****